

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034576

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

FILED SEP 17 1962

Primary Registration District No.

Registrar's No.

153

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ark.</b> b. COUNTY <b>Baxter</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>West Plains</b>		Length of stay in lb <b>One day</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Memorial Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. CITY OR TOWN <b>Gamaliel</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>----</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Hooper</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 6, 1896</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Fisherman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (City and state or country) <b>Houston, Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Nelson Hooper</b>		13b. MOTHER'S MAIDEN NAME <b>Ruth Lovette</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs. Frances Hooper</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mrs. Frances Hooper, Gamaliel, Ark.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Pulmonary Edema</b> DUE TO (c) <b>Chronic Emphysema</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Asthma of 20 yrs or more</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>24 hrs</b> <b>2 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>3:25 AM</b> Month, Day, Year <b>3-21-61</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>West Plains, Mo.</b>		
21. I attended the deceased from <b>3-21-61</b> to <b>8-27-62</b> and last saw her alive on <b>8-27-62</b> Death occurred at <b>3:25 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <b>Murray T. Litchard M.D.</b>	
22a. ADDRESS <b>West Plains, Mo.</b>		22c. DATE SIGNED <b>9-5-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>August 27, '62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gamaliel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Gamaliel, Arkansas</b>
24. FUNERAL DIRECTOR <b>Robertson Fun. Home, West Plains, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-13-62</b>	26. REGISTRAR'S SIGNATURE <b>Beatrice Cook</b>	

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*A. H. Robertson*

Licensed Embalmer No.

*3432*

P. O. Address

*West Plains Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.